



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

INJURY ONE TREATMENT CENTER
PHYSICIAN MANAGEMENT SERVICES
5445 LA SIERRA DR SUITE 204
DALLAS TX 75231

Respondent Name

SERVICE LLOYDS INSURANCE CO

Carrier's Austin Representative Box

Box Number 42

MFDR Tracking Number

M4-08-6084-02
(formerly M4-08-6084-01)

MFDR Date Received

JUNE 4, 2008

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Enclosed are copies of the preauthorization letter, (#79540328-1 & #79540467-01) EOBs, claims, and documentation. The patient was referred for individual psychotherapy. The claims were denied and per EOB extent of injury, not finally adjudicated. The treatment that was provided is part of his compensable injury that he sustained on 01/25/07. Also, the services provided were preauthorized. Please note the claims were also sent to BRC due to extent issues not yet resolved...In summary, it is our position that Service Lloyds has established an unfair and unreasonable time frame in paying for the services that were medically necessary and rendered..."

Amount in Dispute: \$515.19

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Requestor is seeking reimbursement for services performed on June 11, June 25, and July 5 of 2007, in the amount of \$515.19 plus interest for Psychological Evaluation, office visit and additional therapy...The bills were received and properly denied."

Response Submitted by: Harris & Harris for Services Lloyds Insurance Co., P. O. Box 91569, Austin, TX 78709

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 11, 2007	90801	\$183.81	\$0.00
June 25, 2007	90806 90880	\$108.31 \$133.71	\$0.00 \$0.00
July 5, 2007	97140 A9300	\$59.36 \$30.00	\$0.00 \$0.00
TOTAL		\$515.19	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.600 sets out guidelines for preauthorization, concurrent review, and voluntary certification of health care.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated July 13, 2007

- B15 – Procedure/Services is not paid separately
- W12 – Extent of Injury. Not finally adjudicated
- B22 – Payment adjusted based on diagnosis

Explanation of benefits dated October 22, 2007

- B15 – Procedure/Services is not paid separately
- W4 – No additional payment allowed after review
- W12 – Extent of Injury. Not finally adjudicated

Issues

1. Did the requestor bill for treatment of a compensable body area?
2. Is the requestor entitled to reimbursement?

Findings

1. A Decision and Order signed on February 26, 2009 indicates that the claimant's compensation injury of August 28, 2006 does not extend to or include right hand/wrist carpal tunnel syndrome and depression.
2. Review of the submitted documentation finds that services rendered were for the treatment of the non-compensable body area. As a result, the healthcare provider is not entitled to reimbursement.

Conclusion

For the reasons stated above, the division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

November 26, 2012
Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.****

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.